TRANSACTIONS

OF THE

PHILADELPHIA ACADEMY OF SURGERY.

Stated Meeting, May 2, 1904.

The President, HENRY R. WHARTON, M.D., in the Chair.

MULTIPLE NEUROMATA OF THE ARM.

DR. JAMES K. YOUNG exhibited a man of sixty-four years who has always enjoyed good health. Thirty years ago a subcutaneous nodule appeared in the bend of the left elbow over the line of a nerve-trunk. A second one appeared later in the axilla, and then others on the inner and outer aspects of the arm. There are now nine large and several small tumors, the last of which appeared one year ago. (Fig. 1.) They are exceedingly painful, but Dr. Young is inclined to regard them as pseudoneuromata that can be shelled out by operation. The case is a rare one because the new growths are confined to the one extremity and to the distribution of a single nerve.

DR. FRANCIS T. STEWART has operated upon a similar case within the past month. Seventeen tumors were removed from the flexor surface of the arm and forearm. One pathologist pronounced them to be fibromata, and a second reported them as leiomyomata. Clinically they presented the characteristics of fibromata. Some of them were connected with nerves, but the majority were not so related.

DR. WILLIAM J. TAYLOR mentioned the case of a woman upon whom he had operated five times in thirteen years, removing in all thirty-two neuromata from the internal plantar and posterior tibial nerves. In size the tumors varied from that of a small pea to a large filbert. The condition of the foot was so peculiar and pain from pressure so severe that the patient had been known to fall from a chair when a finger-nail was drawn over the tumors; at

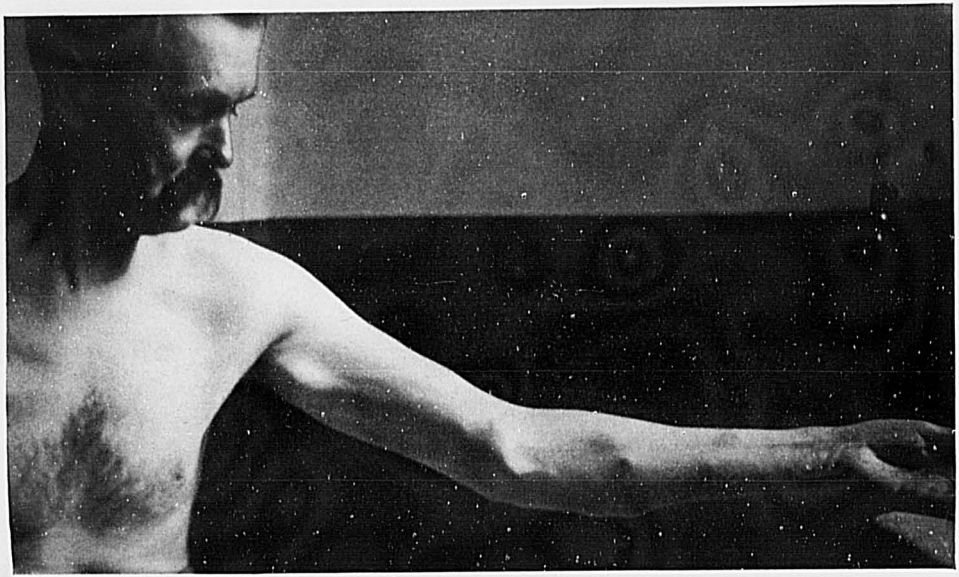

FIG. 1.—Multiple neuromata of arm.

such times large drops of sweat would exude from the skin of the foot. No relief followed repeated removal of the tumors, and finally eight inches of the internal plantar and posterior tibial nerves were removed. Since that the patient has been perfectly well. A careful examination of the tumors by Dr. Spiller showed them to be neuromata. The symptoms in Dr. Young's patient are so different, that Dr. Taylor is inclined to regard the growths as fibromata rather than neuromata.

FRACTURE OF THE LOWER EXTREMITY OF THE RADIUS, WITH ANTERIOR DISPLACEMENT OF THE LOWER FRAGMENT.

Dr. Francis T. Stewart showed two skiagrams of fracture of the lower end of the radius in which the lower fragment was displaced to the palmar side. The patient was a man of fifty years, who had received a blow from a heavy weapon upon the back of the wrist. He thought the injury was only a contusion, and treated it for several days with local application before appearing at the hospital. The injury was treated on a Bond splint.

Dr. John B. Roberts mentioned two recent cases in which the fracture was the same as that described by Dr. Stewart. The first was that of a lady who was thrown from a horse and struck on the back of her hand in such a manner as to drive forward the lower fragment of the fractured radius. Six years ago he saw a similar condition in a man, but does not recall the manner in which the injury was received. The fracture in neither instance had been recognized by the attending physician. Dr. Roberts believes that this fracture is usually not recognized, although it seems there should be no difficulty in the diagnosis. He illustrated by diagrams an easily recognized point in diagnosis which simply depends upon the character of the deformity. As compared with a true Colles's fracture, the deformity is more like that of a gardener's spade than that of a silver fork. This fracture should not be called a Colles's fracture, as that name implies a posterior displacement of the lower fragment of the radius. It has been called a Smith's fracture and a reversed Colles's fracture. He showed a number of casts, photographs, and skiagraphs, as well as two specimens from the Mütter Museum, illustrating this injury.

MOYNIHAN'S CLAMP AND SPLIT-EYED NEEDLES FOR USE IN GASTRO-ENTEROSTOMY.

DR. WILLIAM J. TAYLOR, for Dr. W. W. Keen, showed these instruments. Dr. Taylor in this connection stated that some time since, when desiring to use similar needles, he took split-eyed or calyx-eyed needles, took out the temper, bent them to the desired shape, and retempered them. He found them very satisfactory, in a certain sense answering his purpose better than those of Moynihan.

RUPTURE OF GALL-BLADDER, WITH PROFOUND TOXÆMIA.

DR. JOHN H. JOPSON reported a case of cholelithiasis with rupture of the gall-bladder and extensive peritonitis in a woman of fifty-one years, and the development, after operation, of a peculiar form of toxæmia, with delirium. There was a history of acute cholecystitis seven years before, and of attacks of gall-stone colic somewhat over a year ago, with persisting impairment of health and strength, pain, and indigestion. Preceding rupture, there was an attack of very severe colic lasting over two days, and followed by symptoms of general peritonitis and collapse, with fever and leucocytosis. Operation, seventy-two hours after the onset of colic, revealed a large quantity of bile in the abdominal cavity, and extensive peritonitis, many fresh adhesions, and pockets of bile and mucus as far down as the pelvis. The exact site of perforation in the collapsed gall-bladder was not located. There was an oval stone the size of a date-seed in the first portion of the cystic duct. After drainage of the gall-bladder and peritoneal cavity there was prompt improvement in the local and constitutional condition, and a gradual fall in the leucocyte count, with rapid disappearance of the slight jaundice present before operation. There was no obstruction of the common duct. Immediately after operation the urine contained a moderate amount of albumen, and many casts and some bile were secreted in good amount, and the abnormal constituents gradually disappeared. The pulse remained rapid for ten days. Nine days after operation, the patient became delirious. Her mental condition and general appearance closely resembled those sometimes observed in alcoholic subjects after accident or operation, although there was

no alcoholic history. The face was flushed, the tongue coated, the mind wandering, with hallucinations and delusions. She was very restless at all times, but especially at night, when she was restive and abusive, and required constant watching and restraint to keep her from removing her dressings and from getting out of bed. There was no tremor. The temperature remained at or near the normal line, except for a slight evening rise for a few days, due to slight infection of the pelvic sinus and a stitch abscess. There was free drainage of bile from the gall-bladder. The mental symptoms lasted for a week, at the end of which time they passed off rather quickly. The drainage was removed from the gall-bladder after two weeks. Its removal was followed by a rise of temperature, irregular fever, and occasional chills; it was reintroduced ten days later, and retained for a week, when it was permanently removed, the convalescence being thereafter uninterrupted.

RUPTURE OF THE GALL-BLADDER, WITH GALL-STONES, AND AN ABSCESS PRODUCING PROFOUND TOXÆMIA.

Dr. William J. Taylor reported the case of a married woman aged sixty-four, who had always been well and strong, and who gave no history of fevers, digestive disturbances, nor previous abdominal pain. One sister died at about the same age of what was said to be gall-stones, although there had been no operation to determine this, nor post-mortem examination made. Four weeks before her admission to the hospital, the patient was suddenly seized with pain in the region of the liver and gall-bladder, which was extremely severe in type, and continued with but slight intermissions. She had never been jaundiced, nor especially constipated, and beyond abdominal pain, tenderness, and some fever, there had been no marked symptoms. Her temperature when first seen was 102° F.; there was some rigidity of the right rectus muscle and no abdominal distention, although the belly was full. There was great tenderness, and an indistinct mass over the region of the liver and gall-bladder; the tenderness extending down into the iliac fossa. Her pulse was 80, her tongue fairly clean, and there had been no vomiting. The next day, as her local conditions had not improved materially under fractional doses of calomel, although her temperature had

fallen to the normal, he operated. The liver was much enlarged and covered with lymph. Quite a large quantity of thin, but glairy, yellowish-green pus to the amount of five or six ounces welled out as soon as the peritoneum was opened. There was an immense number of adhesions, and at the edge of the liver over the region of the gall-bladder an abscess was found. There were so many adhesions, that it was difficult to determine the exact relations of the parts. In what had the appearance of an abscess cavity at the depth of two inches a large gall-stone could be felt. This, after considerable dissection through the adhesions, was taken out, and four or five smaller stones were also removed. The gall-bladder was now seen to be ruptured and completely disorganized. All that remained of the gall-bladder was dissected away, and the wound packed with iodoform gauze; a wick of gauze was also passed down into the pelvis for drainage. She had little or no shock following the operation; her temperature once reached 102° F., then fell to the normal line, and remained so for one week, when it again arose to 100° F. for a few days, and again became normal. Almost immediately from the time of operation she showed evidences of a profound systemic toxæmia, such as he had never seen before. Up to the time of operation there were no evidences of anything but a local disturbance, the tongue was heavily coated, almost black, the mouth dry and parched, and this was so pronounced that she could swallow only with difficulty. She was dull, somnolent, and apathetic, but could be roused to answer questions. Her face was very much flushed, but there was no marked jaundice, although the skin was yellowish. She gave the appearance of one who had been on a protracted alcoholic spree, but she was absolutely temperate in all of her habits, and had never been a drinking woman. There were no abdominal symptoms of moment; she complained of little or no pain, and the whole course of her illness was rather against this condition being produced by an ordinary septic intoxication. The fact that the gall-bladder wall was destroyed might have been a producing factor in this profound toxic state. Certainly the toxæmia was one of a very unusual character, and the symptoms not those usually found in septic infection.

The operation was performed on February 24, 1904, and the wound was entirely closed by April 4, when she left the hospital apparently in perfect health.

(1) RUPTURE OF THE GALL-BLADDER IN ACUTE CHOLECYSTITIS. (2) RUPTURE OF A BILE-DUCT FOLLOWING CHOLECYSTOTOMY WITHOUT DRAINAGE.

Dr. Robert G. Le Conte said that in briefly reporting these two cases, which of themselves are not of any great surgical interest, he did so as an antithesis to the two cases reported by Drs. Jopson and Taylor, in which a certain group of toxic symptoms were present, attributed to the presence of bile in the peritoneal cavity. In the cases he was about to report these toxic symptoms did not appear.

Case I.—L. L., aged thirty-one years, laborer, born in Italy, was admitted to the Pennsylvania Hospital, December 21, 1903, with the diagnosis of acute suppurative appendicitis. Patient had been ill for three days with pain in the right side of the abdomen, rigidity of the right rectus, considerable tenderness, chills, fever, and vomiting. On admission his cheeks were flushed, tongue clean, no jaundice, chest negative, liver dulness increased, extending from the fourth interspace to two inches below the costal margin. Abdomen slightly distended; great tenderness of the upper right quadrant; marked rigidity of the right rectus. No tumor could be outlined in the region of the gall-bladder owing to the tenderness and rigidity. The appendiceal region was negative to examination. *Urine,* slight trace of albumen, hyalin and granular casts, no bile pigment, leucocytes 12,500. Widal reaction slightly suggestive. Temperature varied from 101° to 103° F. Diagnosis, acute suppurative cholecystitis. Operation refused.

Treatment consisted of an ice-cap to the abdomen, milk diet, with the exhibition of small doses of calomel and phosphate of soda. In a week the temperature had dropped to normal, the pain disappeared, but slight tenderness and rigidity persisted. By the end of the second week tenderness and rigidity had also disappeared and the patient seemed to have entirely recovered. He refused to remain longer in the hospital, and was discharged January 7, 1904.

Readmitted January 16, 1904. Abdominal symptoms practically the same as on previous admission, temperature ranging from 102° to 103.5° F.; urine negative; leucocyte count, 10,400.

January 18. Ether was administered and incision made in the right rectus muscle over the gall-bladder. The gall-bladder was found firmly embedded in a mass of adhesions and covered

by the colon. On separating these adhesions a pericystic abscess was found in the region of the neck of the gall-bladder, perforation of that organ having taken place just above the cystic duct. The abscess outside of the gall-bladder contained perhaps one ounce of pus, while the gall-bladder itself was distended with a purulent secretion. After swabbing out this pus, the adhesions about the cystic and common ducts were found so dense that it was thought inadvisable to attempt an exposure of these ducts or to attempt an excision of the gall-bladder. An opening was made in the fundus of the gall-bladder and a rubber tube passed to its lowest point. Another rubber tube was passed to the bottom of the abscess cavity outside of the gall-bladder, and some iodoform gauze wicks were also introduced. Two silkworm-gut sutures partially closed the abdominal wound. Recovery was uneventful. The temperature soon fell to normal; pain disappeared; pus was discharged freely for a week without a trace of bile. At the end of six days the gauze wicks were removed, and at the end of two and one-half weeks the rubber drainage tubes also. At the end of two weeks the purulent discharge had ceased and bile was flowing freely through the drainage tubes. He was discharged with a very small sinus discharging bile on February 19, the rest of the wound having entirely healed.

In reporting the second case, he called attention to the fact that the operation was undertaken five years ago, at a time when the advantages of drainage of the gall-bladder were not perfectly understood, and that the operation performed in this case—the so-called ideal operation—cannot be justified in the light of our knowledge of to-day. He was led to do it at that time on account of having had two cases previously that made uneventful recoveries, in which the pathological lesions were similar to this one.

Case II.—I. G., aged forty-five years, a Russian, was admitted to the medical wards of the Pennsylvania Hospital in August, 1899. He gave a history of cholelithiasis extending over a period of more than six years, with from two to three sharp attacks of colic each year. On admission jaundice was visible in the conjunctivæ and in the skin over the chest and abdomen. Liver dulness was not increased; palpable tumor in the region of the gall-bladder, with tenderness and rigidity of the upper right rectus muscle, but no fever.

Operation, August 18, 1899. Incision through right rectus; universal adhesions about the gall-bladder and ducts; gall-bladder much distended, filled with gravel varying in size from sand to buckshot. Cystic and common ducts also distended with same material. This material was removed, and the gall-bladder and ducts flushed with salt solution; gall-bladder was then closed with catgut sutures and the abdomen closed without drainage. The jaundice disappeared, and the recovery was uneventful. Discharged September 11, 1899.

Readmitted September 18, 1899, one week from the previous discharge, with abdominal pain and tenderness in the epigastric and right hypochondriac regions; much jaundice; vomiting; increasing distention of the abdomen and rigidity of the right side. September 21, as Dr. Le Conte was absent from the city, an incision was made alongside of the old scar by Dr. T. S. K. Morton. On opening the abdomen bile immediately escaped. Many adhesions were present. The gall-bladder was exposed, but no rupture could be found, and the scar at the fundus from previous operation was sound. Owing to the adhesions, the cystic and common ducts were not well exposed, but with such exploration as was made no rupture could be demonstrated. The abdominal cavity was washed out and packed with iodoform gauze. The recovery was uneventful. The amount of bile discharged from the wound grew less and less, and in three weeks had entirely ceased. He was discharged October 18 with a small granulating area in the region of the wound.

In view of the fact that jaundice was marked and that the exposed portions of the gall-bladder, especially the seat of the previous incision, were found sound, he judged that some portion of the common duct had ruptured, owing perhaps to some kinking due to the many and firm adhesions surrounding it.

Dr. Le Conte further remarked that so many cases had been reported where bile was present in the peritoneal cavity without producing profound toxic symptoms, that one must eliminate many other factors before concluding that such toxæmia is caused by the peritoneal absorption of bile. As in appendicitis, such symptoms can readily be produced from the presence of septic material in the bile, or, as in uræmia, from the lack of eliminating powers of the kidney. Again, if no bile is entering the intestine, the possibility of auto-intoxication from intestinal contents would have to be eliminated. To his mind such profound toxæmia is

more likely to have been produced by absorption of purulent products by the peritoneum, which products were perhaps not eliminated by the kidneys. Under such circumstances the presence of bile in the peritoneal cavity would be simply a coincidence and not a causation of the symptoms.

ACUTE CHOLECYSTITIS WITH GALL-STONES IN A GIRL OF SEVENTEEN.

DR. E. HOLLINGSWORTH SITER reported the history of a girl, aged seventeen years, who was admitted to St. Agnes's Hospital, February 10, 1904, with the following history: On February 5 (five days ago) patient was seized with pain, of a severe character, about the umbilicus, followed by vomiting. The pain rapidly spread over the entire abdomen, and in thirty-six hours localized itself over the appendiceal region. Vomiting was not fæcal, but contained bile. There had been no constipation and no jaundice.

Examination of the patient shows her lying on her left side with the right leg flexed. Palpation showed slight rigidity more marked on right side, abdomen was slightly distended and somewhat tympanitic.

An incision was made over the gall-bladder and extending down towards the appendix. The gall-bladder was found greatly distended, and upon being opened a large amount of fluid and several stones were found. The stones were slightly smaller than a split pea. The appendix was examined and found gangrenous. It was removed.

The patient made an uninterrupted recovery, but continued to discharge small stones until the eighth day after the operation.

DR. FRANCIS T. STEWART, speaking with reference to toxæmia following operations for cholecystitis, referred to a case under his care. The patient when admitted was suffering from symptoms that indicated violent cholecystitis. The condition came on acutely at 11 A.M., and operation was performed at 8 the same evening. Pus was found in the gall-bladder, and in the cystic duct was an impacted stone. The temperature was 102° F. before operation. Afterwards the tongue became coated, the face was flushed, and delirium developed. Later there was hæmorrhage from the bowel, the spleen became enlarged, the Widal reaction was positive, and rose spots appeared, the patient passing through a typical attack of typhoid fever. Cultures from the gall-bladder showed the

presence of streptococci. Dr. Stewart also mentioned a case in which he assisted Dr. Morton. The symptoms were those of an acute abdominal catastrophe, and the abdomen was found to be filled with bile. The bile was allowed to drain from the abdominal cavity, and it was not known if rupture of the gall-bladder had occurred. The patient went on to recovery without developing any evidence of toxæmia.

Dr. W. Joseph Hearn stated his belief that bile in the peritoneal cavity produces no more toxic effects than does any other foreign body. He cited the case of a man who was shot through the gall-bladder, with consequent escape of bile into the peritoneum; no toxæmia referable to the presence of bile developed. Cases of toxæmia similar to those reported are due to streptococcus or staphylococcus infection in addition to the bile.

Dr. John H. Gibbon cited cases of Dr. Willard and others in which bile from a ruptured normal gall-bladder had remained in the peritoneal cavity for long periods of time, in Dr. Willard's case for many months, without producing untoward effects. He agrees with Dr. Le Conte that micro-organisms produce the trouble in the beginning, and also the subsequent toxæmia. Intoxication results from the release of pent-up material in the gall-bladder.

Dr. John H. Jopson stated that he did not mean to imply that the symptoms in his case were due to absorption of bile, as he is not sure that they were. They came on a week after the bile was drained. As to septic infection, however, granulations had formed and walled off the wound, and the leucocyte count was falling, conditions in which one would not expect to find infection. He thinks that the symptoms were not due to an ordinary infection. Usually, bile is very well borne by the peritoneum.

Dr. William J. Taylor stated that he had reported his case simply as one of profound toxæmia which came on some time after operation and lasted a week or ten days. He has never seen any other intoxication resembling it.

Dr. Gwilym G. Davis detailed briefly the case of a man of seventy years who had gangrene of the gall-bladder which contained a calculus. An abscess outside of the gall-bladder was also present. The abscess was evacuated, the bladder removed, and drainage instituted. The patient did well for a week or two, then developed delirium, and later insanity. Death finally ensued. There was no evidence of peritonitis or sepsis.

Dr. Robert G. Le Conte said that the urine report in the case presented by Dr. Jopson was interesting and very suggestive. Previous to the time of the appearance of the toxic symptoms in the patient the analysis of the urine showed albumen, casts, and granular débris to be present. Coincident with the appearance of toxæmia, the urine cleared up and was apparently normal, suggesting, perhaps, that, owing to the failure of the kidneys to eliminate the toxic material in the blood, the constitutional symptoms of toxæmia had presented themselves. In other words, that as long as the kidneys were excreting the toxic products in the circulation no constitutional symptoms were present, but the moment they ceased this elimination the symptoms of toxæmia appeared.

SUPPOSED CARCINOMATOUS OBSTRUCTION OF THE PYLORUS NINE MONTHS AFTER POSTERIOR GASTRO-ENTEROSTOMY.

Dr. John H. Gibbon presented a woman, thirty-eight years of age, saying that his reason for reporting this case was that it illustrated the difficulty of making an accurate differential diagnosis between gastric cancer and ulceration of the stomach where there is a large amount of infiltration about the ulcer, and also the advisability of performing gastro-enterostomy even where the operation may seem useless because of the extent of the supposed malignant disease.

The patient was seen with Dr. Gamble and gave a typical history of gastric ulcer extending over eight years. Her family and previous history were of no particular interest. For eight years the patient had suffered from attacks of vomiting and gastric pain. She had also suffered pain soon after eating. The attacks grew worse, and six years ago she was confined to bed by one of them for three months. During this attack she had two hæmorrhages from the bowel, followed later by the passage of clots. She states that she passed no blood after this time. A year later she had another attack, which kept her in bed for a month. In both of these attacks there was severe pain in the right side and in the back. Two years ago she had an acute attack of vomiting and was very ill. The material vomited was very dark and said to contain blood. This is the only attack of hæmatemesis which the patient has had. During this attack she was confined to a hospital

in Philadelphia for six weeks, the diagnosis of gastric ulcer being made. In January, 1903, the patient was able to return to her work as a housemaid, at which she continued uninterruptedly until four days before Dr. Gibbon saw her, July 29, 1903. Three weeks before he saw her she began to have trouble with her digestion, and occasionally vomited a moderate amount, which greatly relieved her discomfort. During these three weeks she had more or less pain located above and to the right of the umbilicus, a feeling of distention of the upper abdomen, and constipation. When first seen by Dr. Gibbon she had a great deal of gastric pain and tenderness. The stomach was distended and contained a large amount of liquid food, which the patient had been able to take without any recent vomiting. The lower border of the organ extended some inches below the umbilicus. After examination of the abdomen the patient vomited an enormous amount of dark liquid, after which the stomach could not be outlined, and the patient felt more comfortable. At this time it was noted that there was a sense of resistance above and to the right of the umbilicus.

The patient was admitted to the Pennsylvania Hospital on July 29, 1903, and for eight days was fed entirely by the rectum. The second day after admission she vomited, the vomitus containing a quantity of undigested food and berry seeds, eaten some time before. The stomach was washed out at this time, and vomiting did not recur for some time. On August 1, after a test meal, there was found free hydrochloric acid, total acidity 65, combined acids 36, no lactic acid. The hæmoglobin at this time was 71 per cent. For the next three or four days the patient vomited a number of times, and the vomited material was found to contain blood. No blood was present in the stools, however. On August 7 Dr. Gibbon determined to do a gastro-enterostomy, and expected to find a benign obstruction of the pylorus. When the abdomen was opened, there was a mass involving the pylorus about the size of a lemon, which was hard and appeared to be a cancer. The glands of the lesser omentum were very numerous and large. The patient was not in the best condition, and it was thought unwise at this time to do a partial gastrectomy. A gastro-enterostomy after the method of Moynihan with the Doyen forceps was done, and it was hoped that if the patient recovered from this operation that a partial gastrectomy might later be performed. The patient made a good recovery from the operation, and on the second day was

able to take and retain liquid food. On the fifth day after operation, preceded by a night of considerable pain, there was some distention of the abdomen, which was relieved by an enema; the result of the enema was a large, dark-colored bowel movement. The patient continued to complain of considerable pain at night in the right side of the abdomen. On the tenth day after operation she vomited a small amount of brownish fluid containing small blood-clots. Twenty days after operation there developed a phlebitis of the left leg. This, however, subsided after a day or two, and the patient's condition was much better. On the 11th of September the patient was out of bed and doing well. She was discharged from the hospital on the 21st of September, 1903, a very unfavorable prognosis being given to her relatives. On the 14th of October she had gained both weight and color, felt perfectly well, was eating everything that she cared for, and her only complaint was the swelling of her leg. This was relieved, however, by an elastic bandage. On the 10th of February, 1904, the patient was seen again and presented no gastric symptoms whatever. She had continued to gain in weight, but complained of some pain in the epigastric region and back, which, however, was uninfluenced by the taking of food. This disappeared, and the patient resumed her work as a chambermaid. The pain in the back, however, was sufficient to make her discontinue the work after three weeks. During all this time she continued to take ordinary food without the slightest discomfort. At the present time the patient states that she is entirely free from pain, has no gastric symptoms, and has gained much in weight. Palpation of the abdomen does not reveal any mass whatever in the pyloric region, and the patient's appearance is that of a healthy person.

In view of the condition of this patient nine months after operation, it is thought that she undoubtedly did not have a cancer at the time of operation, but a pyloric ulcer with extensive infiltration about it. It is thought that the case shows the advisability of exploratory operation even where a supposed cancer of the stomach has advanced to the point where it can be palpated through the abdominal wall, and also that in such instances, where there may be the slightest doubt as to the diagnosis, a gastro-enterostomy is advisable.

Dr. Gibbon also referred to another case of perforated gastric ulcer which he reported before the Academy last fall, and reported

in "American Medicine," in which the condition of the stomach about the ulcer so closely resembled a malignancy that, had not perforation been present, a diagnosis of gastric cancer would have undoubtedly been made. This patient was operated upon October 1, 1903, and is now in perfect health.

MR. COLLINSON, of Leeds, England, noted particularly the statements of Dr. Gibbon that the glands in the lesser omentum were involved; enlargement of these glands is quite constantly seen in cases of ulcer of the stomach, and if, in addition, there is extensive induration, one is apt to be led to the diagnosis of malignant disease. The case reported by Dr. Gibbon emphasizes what has been said by Robson, Moynihan, and others, and no doubt explains the remarkable way in which supposed cancer of the pylorus is cured by gastro-enterostomy, the explanation being simply that such cases are in reality those of severe gastric ulcer. The after-history of occasional vomiting by Dr. Gibbon's patient is also interesting. In many cases one sees after operation these attacks, which later entirely disappear. Mr. Collinson is not sure of the explanation of this phenomenon, as it occurs even when the anastomosis is made at the lowest part of the curvature of the stomach, a point which is much insisted upon by experienced surgeons. Vomiting more frequently occurs in cases where the anastomosis is not made at the most dependent point, but the fact that it does sometimes occur in ideal cases is proof that the site is not alone responsible for this annoying sequel.

DR. RICHARD H. HARTE reported briefly a case similar to that of Dr. Gibbon's. The patient was a man about forty-five years of age, who had a large indurated mass in the pyloric region simulating malignancy, and his age lent weight to this supposition. On exploration the mass was found to be caused by the induration following a chronic ulcer. A gastro-enterostomy was performed, and the patient since that time has steadily improved and gained in weight, and all gastric symptoms have disappeared. Had not this case been operated upon, the case might have been put aside as one of malignancy, and the patient would gradually have worn himself out as the result of the chronic irritation about the pylorus, due to an old ulcer. Dr. Harte feels convinced that many of these cases of presumable malignancy can be greatly benefited by operation, and would advise in all doubtful cases that an exploratory operation be performed; if conditions are such as to indicate a posterior gastro-enterostomy, it should be performed.